

SENT VIA EMAIL OR FAX ON
Jan/24/2011

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Discogram

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Anesthesiologist/Pain Management

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. The patient reportedly sustained an injury to the low back while twisting and lifting tortilla dough. After failing to improve with conservative treatment, the patient underwent right L4-5 laminotomy, discectomy and foraminotomy on 10/06/06. The patient was treated conservatively with chiropractic care, medications, epidural steroid injections, but remained symptomatic. He subsequently underwent a right wide L4-5 laminotomy, discectomy, foraminotomy, and Cicatrix removal on 10/19/07. The patient was noted to have developed postlaminectomy syndrome. He underwent right L4-5 transforaminal epidural steroid injection on 06/18/10 without relief. The patient was recommended to undergo psychiatric evaluation to determine if there were any psychological barriers preventing him from benefiting from spinal arthrodesis. The request for psychological evaluation was denied, but the determination was overturned on IRO. The IRO opinion noted the patient appeared to have undergone numerous invasive procedures including past surgeries from which he has seemed not to benefit. If surgery is to be considered again he would need to be cleared from psychological standpoint at this time;

therefore, psychological screening with testing was recommended. The patient was seen by Dr. on 11/15/10 for Independent Medical Evaluation. Dr. noted that repeat psychological evaluation would not be unreasonable to determine the individuals current state as it relates to treatment; however, he would not agree with a discogram pointing out discograms are specifically not recommended by ODG. Dr. further noted he could agree with decompression procedure of L4-5 level to address encroachment on L5 nerve root, but would not be in favor of multilevel fusion procedure. The patient was seen by Dr. on 12/22/10 with complaints of low back pain and right leg pain. The patient was noted to want surgery. Imaging studies were reviewed including MRI of lumbar spine from 2009. The examination revealed prior surgical scar vertical L1-L5. Motor strength testing reported biceps femoris 4/5 right, 5/5 left, 4/5 right quadriceps, 5/5 left, 4/5 right tibialis anterior, and 5/5 left, 3/5 right gastrocsoleus, and 5/5 left. Straight leg raise was positive bilaterally. Light touch and pain sensation deficit was noted to right L5 and right S1 distribution. Deep tendon reflexes were 1/4 at the bilateral patellar tendon, 0/4 left Achilles tendon, and 2/4 right Achilles tendon. According to Dr. a third surgical procedure with Dr. is planned, and Dr. will not schedule pre-surgical follow-up until he has discogram results.

A utilization review by Dr. on 12/09/10 determined the request for lumbar discogram was non-certified as medically necessary. Dr. noted clinical documentation indicates the claimant has undergone two prior lumbar surgeries at L4-5 level. The patient has been repeatedly recommended for lumbar discogram and lumbar fusion at L4-5 level. Dr. noted that Official Disability Guidelines do not recommend lumbar discography secondary to lack of scientific evidence to support safety and efficacy of treatment. As such, it was determined the clinical documentation provided does not support certification of the request at this time.

A reconsideration / appeal request for lumbar discogram was reviewed by Dr. on 12/30/10. Dr. noted that the patient complains of low back pain. He further noted that the guidelines do not support discogram as diagnostic modality, and as such the request is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Based on the clinical information provided, medical necessity is not established for lumbar discogram. The patient sustained an injury to low back in xxxx. He is status post 2 previous surgical procedures on the right at L4-5 level. The patient is diagnosed with postlaminectomy syndrome. He has been recommended to undergo lumbar fusion procedure. Official Disability Guidelines reflect that lumbar fusion is option following two failed discectomies at same level, and the patient does meet these criteria; however, ODG guidelines do not support use of discography results as preoperative indication for lumbar fusion. The guidelines note that recent high quality studies have suggested that concordance of symptoms is of limited diagnostic value. It was also noted that findings of discography have not been shown to consistently correlate well with findings of high intensity zone on MRI.

Moreover, the test itself was found to produce significant symptoms in non-back pain controls more than a year after testing. Accordingly, the request for lumbar discogram is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)